The PCC Plan Handbook

A Guide for MassHealth Primary Care Clinicians

Fourth Edition
June 1999

Commonwealth of Massachusetts • EOHHS • Division of Medical Assistance

The PCC Plan Handbook
Table of Contents

Introduction

The PCC Plan

The Primary Care Clinician (PCC) Plan is administered by the Massachusetts Division of Medical Assistance (the Division). The PCC Plan, a managed care option for certain MassHealth members, ensures that each member who chooses or is assigned to the PCC Plan is enrolled with a PCC who will:

- deliver primary and preventive care services; and
- coordinate most other health care services.

The PCC

The PCC provider network includes individual physicians, group practices, community health centers, outpatient departments, and independent nurse practitioners. In this handbook, the term PCC refers to the type of practice contracting with the Division and to the individual clinicians within a particular PCC practice.

The PCC Plan Handbook

This handbook provides an overview of the PCC Plan. It includes valuable information designed to help you with service delivery and administrative requirements for the PCC Plan. However, both the PCC Agreement and the Division's regulations take precedence over this handbook. Call the Division's Provider Enrollment Unit at 1-800-322-2909 to request copies of the PCC Agreement and Division regulations. For additional copies of this handbook, call the PCC Plan Hotline at 1-800-682-1061.

The PCC Plan
Part 1: Service Delivery

Enrollment

Managed Care

An individual who becomes eligible for MassHealth may also be required to enroll in a managed care plan. Managed-care-eligible MassHealth members must enroll in either the PCC Plan or a MassHealth-contracted managed care organization (MCO).

Health Benefits Advisors

Health Benefits Advisors (HBAs) educate and enroll MassHealth members into one of many health plan options available through MassHealth. These health plan options include the PCC Plan or an MCO. HBAs provide members with information about managed care and help them choose a health plan and a doctor. Members who do not choose a health plan will be assigned to one—either a PCC or an MCO—by the Division.

The Member and the PCC

If a member enrolls in the PCC Plan, both the member and the PCC receive an enrollment confirmation letter. When a member selects a PCC that is a group practice, community health center, or hospital outpatient department, the PCC must assign the new member to an individual clinician within the PCC practice. The PCC practice is responsible for the member's care, even if the member has not chosen a specific clinician within the practice.

Questions

For more information about enrollment, call the PCC Plan Hotline at 1-800-682-1061. Members with questions may call the MassHealth Customer Service Center at 1-800-841-2900.

The Initial Visit

Introducing the PCC Plan

Initial visits should orient new members to the PCC Plan and include a medical history and a physical examination. PCCs should conduct an initial visit for each new PCC member within four months of enrollment.

All initial visits must be made in person and documented in the member's medical record.

Scheduling Initial Visits

To ensure that the initial visit occurs within four months of enrollment, PCCs must try to contact new members, by mail or phone, within three weeks of enrollment. The PCC should document attempted contacts in the member's medical record. If you are unable to contact a member, call the PCC Plan Hotline at 1-800-682-1061.

An initial visit for a child must be scheduled at the age when the child is due for well-child-care services according to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) schedule or within four months of enrollment, whichever is sooner.

Medical Component

For new members, take a medical history and perform a physical examination. For members who are established patients, complete a physical examination if you have not performed one within the last 12 months. For children, you should provide all age-appropriate well-child care during this visit. (See "Well-Child Care" on page 3-4 of this handbook.)

PCC Plan Orientation

A comprehensive orientation will benefit both your PCC Plan members and your practice. For information about member orientation materials, call the PCC Plan Hotline at 1-800-682-1061.

At the initial visit, you should provide all members with a PCC Plan orientation that includes the following:

- **The Importance of Primary Care**

  Explain the importance of primary and preventive care and your role as the PCC in managing and providing that care. Also, explain that a member must have a referral from you for most specialty care.

- **Services Not Requiring a Referral**

  Tell members that the following services do **not** require a referral from you:

  - behavioral health (mental health and substance abuse) services;
  - dental services;
  - emergency services;
  - family planning services;
  - HIV testing and counseling; and
  - vision services.

  See Appendix A of this handbook for a more comprehensive list of services that do not require a PCC referral.

- **Emergency and Urgent Care**

  Explain the difference between urgent and emergency care. Tell members that in an emergency they should go directly to an emergency department. However, urgent care in the emergency department may require your authorization. Stress that members must call you for urgent care between the hours of 8:00 A.M. and 9:59 P.M. before seeking care elsewhere. (See "Emergency Care" on page 1-9 of this handbook.)

PCC Plan Orientation *(cont.)*

- **Carrying the MassHealth Card**

  Emphasize the importance of carrying the MassHealth card, which enables providers to check MassHealth eligibility and identify the member's PCC.

- **Helpful Telephone Numbers for Members**

  Make your members aware of the following telephone numbers in addition to your own. (See Appendix B of this handbook for other important telephone numbers.)

  MassHealth Customer
  Service Center 1-800-841-2900

  Behavioral Health questions
  or referrals.....1-800-495-0086

- **Your Own Practice Specifics**

  Describe such issues as:

  - the days and hours that your practice is open
  - the importance of keeping appointments
  - cancellation procedures
  - how to contact you after hours
  - alternate telephone numbers
  - whom the member should speak to when they call
  - who will call the member back
  - how long the member should expect to wait for a return call
  - office "call-in" hours

Referrals

Introduction

As a PCC, you are responsible for referring your members for MassHealth-reimbursable services, when medically appropriate, such as specialty care and certain ancillary services. When making referrals, consider the member's prior relationship with a specialist, patient choice, location, and whether the specialist is a MassHealth provider. Providers will not be reimbursed for services to members enrolled with you as their PCC **unless**:

- they have received a referral from you;
- they are MassHealth providers; and
- the service is otherwise reimbursable by MassHealth.

See Appendix A of this handbook for a list of services that do **not** require a referral.

Three Ways to Make Referrals

Make referrals by:

- telephone;
- using the MassHealth Referral Form (Appendix C of this handbook); or
- using your own referral form.

Required Referral Information

When referring a member to another provider, always tell that provider how to use your PCC referral number to make future referrals (see "The PCC Referral Number" on page 1-6), such as ordering ancillary services. Also tell the provider when you want a report of the findings.

All referrals must include the following information:

- reason for the referral;
- services requested;
- number of visits or services authorized;
- duration of the referral; and
- any other referral specifications, at your discretion as the PCC.

The PCC Referral Number

Your MassHealth provider number also serves as your PCC referral number. This number must be entered on all claims submitted by the referred provider. **Without it, the Division will not pay the claim.**

For a group practice, community health center, or hospital outpatient department, the referral number is your practice's "Pay-to" MassHealth provider number, not your individual MassHealth provider number.

Referral Documentation

All referrals, whether made by telephone or by referral form, must be documented in the member's medical record. Specialists must also document the referral and report back to the PCC on the services provided or if the services were not accessed by the member.

Blanket Referrals

You may make blanket referrals for up to 12 months for specialty care that addresses a specific illness or chronic condition. You must renew the blanket referral after 12 months. All claims submitted within a blanket-referral period must include the PCC provider number.

Referral Before an Initial Visit

- **Primary Care**

  When a member does not choose a PCC, the member will be assigned to a PCC or MCO by the Division. Some members may already have an established relationship with you and then get assigned to another PCC or MCO. When this happens and the member presents at your office, you must get a referral from the PCC or MCO, in order to be eligible for reimbursement, either from the Division or the MCO.

  Members may change PCCs by calling the MassHealth Customer Service Center at 1-800-841-2900. See "Changing Providers" on page 2-4.

Referral Before an Initial Visit *(cont.)*

- **Specialty Care**

  A specialist may request a referral before you have seen the member or, in some cases, before you are aware that the member is enrolled with you. The decision to approve or deny a referral request is up to you. You may decide that you do not have enough information about the member to authorize the service because you have not yet seen the member for an initial visit. In certain circumstances, you may decide that authorizing the service for one time only is appropriate.

Referrals for Prenatal Care

PCCs are encouraged to make appropriate referrals for obstetric care upon request from pregnant members, or as soon as you are aware that a member is pregnant. If a new member requests a referral for obstetric care before you have seen her, authorize the referral to an obstetric provider to facilitate early prenatal care. Investigate a member's possible relationships with prenatal care providers and try to maintain continuity with those providers if appropriate.

Referrals for Primary Care

- **General**

  Authorize referrals for primary care **only** if you cannot see the member within a reasonable time period. PCCs are expected to personally provide primary-care services to their members.

- **Adolescents**

  To increase adolescent access to primary-care services, you may refer adolescent members to MassHealth-participating school-based health centers, which serve as a resource for PCCs in providing primary and well care to adolescent members. School-based health centers require a referral from the member's PCC to deliver most services. If you have any questions about school-based health center services, call the PCC Plan Hotline at 1-800-682-1061.

Denying Referral Requests

Only the PCC or the backup physician, not office staff, may deny requests for referrals. See your PCC Provider Agreement for more information.

Retroactive Referrals

You may grant a retroactive referral at your discretion.

When a Referral Is Not Used

If you discover that a member did not access referred care, try to contact the member and determine the reason. Encourage the member to reschedule and keep the appointment if the care is still necessary.

Emergency Care

Introduction

As the PCC, you have the authority and responsibility to manage your members' care. You should personally provide their primary and well care. You may authorize appropriate, medically necessary care and deny authorization for inappropriate care.

You should also personally provide urgent care whenever circumstances permit. However, urgent care may also be provided by other providers, including emergency departments. Emergency services should be provided in a hospital emergency department. The following rules apply for PCC authorization for different levels of care.

Emergency Services

Emergency services **never** require a PCC referral.

Urgent Care in an Emergency Department

- **From 8:00 A.M. to 9:59 P.M.**

  Urgent care in a hospital emergency department requires that the emergency-department physician contact the member's individual PCC or the backup clinician for a referral between the hours of 8:00 A.M. and 9:59 P.M. If you, as the PCC, do not respond to the request within 30 minutes, the emergency department will treat the member without your approval. In such cases, the hospital must notify you within 24 hours after the delivery of urgent care.

  Please Note: A health-care professional designated by the PCC may issue authorizations or referrals, but only the PCC or physician backup can deny authorization of care.

  If you or your backup physician deny authorization for the services, the emergency-department physician will discharge the member to your care, provide written discharge instructions, and emphasize the need for the member to return to the care of his or her PCC.

Urgent Care in an Emergency Department *(cont.)*

- **From 10:00 P.M. to 7:59 A.M.**

  Your PCC referral is **not** required for urgent care in a hospital emergency department between the hours of 10:00 P.M. and 7:59 A.M. The hospital is still required to notify you within 24 hours after delivering urgent care.

Urgent Care by Other Providers

You may, at your discretion as the PCC, grant referrals to other providers for the delivery of urgent care.

Primary or Elective Care in an Emergency Department

Do **not** authorize primary or elective care in an emergency department. Emergency-department physicians and other emergency-department staff must refer members who seek primary or elective care back to you. See the Division's administrative and billing regulations at 130 CMR 450.000 in Subchapter 1 of your provider manual for more information about emergency-department services and levels of care.

Emergency Department Screening

Federal law requires hospital emergency departments to perform medical screening exams of all individuals seeking services in an emergency department. No PCC referral is required for this screening.

If the member's level of care is primary or elective, the emergency-department physician must refer the member back to his or her PCC and remind the member to seek elective or primary care services from his or her PCC.

Hospitalization

Hospital Admission

All elective admissions require PCC authorization. All nonelective admissions require the hospital to notify the PCC within 24 hours and obtain a PCC referral number.

When the PCC Is the Admitting Physician

When the PCC is the admitting physician, the PCC must oversee all of the member's care in an inpatient setting, including authorizing services, conducting rounds, and assisting with discharge planning.

When the PCC Is Not the Admitting Physician

When the PCC is **not** the admitting physician, the physician who admitted the member will assume responsibility for the member's hospital stay. A referral from the PCC is required within 24 hours of admission for all nonelective hospital admissions.

Preadmission Screening

Preadmission screening is performed by MassPRO for **all** elective medical and surgical admissions. PCCs are notified of the results of all preadmission screenings. Questions about preadmission screening can be directed to MassPRO at 1-800-732-7337.

The PCC Plan
Part 2: Administration

Billing

Introduction

PCCs receive enhanced rates for most office and home visits provided to their PCC Plan members. All statutes, regulations, rules, billing instructions, and provider bulletins governing MassHealth claims submission apply to the PCC Plan.

Special Billing for Well-Child Care

PCCs may receive an additional enhancement for well-child care services when delivered in accordance with the EPSDT schedule. For your convenience, the Division has produced "Well-Child Care Billing Vignettes" that may answer your questions about billing for EPSDT services.

For a copy of "Well-Child Care Billing Vignettes," write or fax your request to:

Unisys
ATTN: Forms Distribution
P.O. Box 9101
Somerville, MA 02145
Fax: (617) 576-4087.

Questions

For answers to billing and claims payment questions, call the Provider Services Department at (617) 628-4141 or 1-800-325-5231.

Member Access

Telephone Access

You must have a 24-hour, seven-day-a-week telephone system that either:

- connects a member to an individual who can contact you or your backup physician when necessary; or
- directs the member to contact you or your backup physician at another number. (Telephone systems may **not** direct members to an emergency department for backup coverage.)

Backup Physician

You must arrange, when necessary, for a backup physician who is familiar with your responsibilities as the PCC. Your backup physician must be able to provide primary care, make referrals, and authorize urgent care in the emergency department using your PCC referral number.

Backup Reimbursement

Remember:

- Your backup physician must be a MassHealth provider in order to be reimbursed.
- Your PCC provider number must be included on the claim form as the referring provider number.
- Your backup physician will **not** receive an enhancement for services provided to your PCC Plan members.

Reports

Introduction

The Division issues two reports to help PCCs manage their practices. These reports are described in this section.

PCC Panel Report

All PCCs receive the PCC Panel Report. This monthly report separately lists new, ongoing, and disenrolled members since the last report. Information for each member includes:

- member name;
- MassHealth member identification number;
- sex;
- date of birth;
- PCC enrollment or disenrollment date; and
- MassHealth head of household (case head) name.

PCC Profile Report

All PCCs with 200 or more PCC Plan members receive the PCC Profile Report every six months. The PCC Profile Report contains clinical measures that may change. The PCC Profile Report currently contains the following clinical measures:

- admissions and emergency-department visits for asthma;
- emergency-department utilization.
- mammography screening;
- Pap-smear screening;
- well-child care;

The PCC Profile Report also compares the PCC practice's rates with either the best practices within the PCC Plan or industry benchmarks. Member-specific information is also included with the PCC Profile Report.

Member Rights

Changing Providers

PCC Plan members may transfer to a different PCC upon request. Members may select a new PCC by calling the MassHealth Customer Service Center at 1-800-841-2900. A transfer to a different PCC becomes effective after one business day.

Complaints and Grievances

Most member concerns can be addressed by you, as the PCC. Members may also call an HBA to help them with a particular issue. HBAs informally resolve many member concerns. If a member's concern cannot be resolved by either you or an HBA, a member may file a formal complaint with the Division at the following address:

Division of Medical Assistance
ATTN: Assistant Commissioner for Member Services
600 Washington Street
Boston, MA 02111.

Requesting Member Transfer

Transfer Request

To request that the Division transfer a member from your PCC panel, you must demonstrate that the member has shown a pattern of disruptive or noncompliant behavior, or provide other good cause for the request. The PCC Plan staff review all such requests and will transfer a member only when they determine there is good cause.

To request a member transfer, call the PCC Plan Hotline at 1-800-682-1061. Be prepared to provide the following member information:

- member name;
- MassHealth member ID number;
- member's address;
- telephone number; and
- reason for the request.

Transfer Process

Some transfer requests are subject to an outreach effort by the Division's Customer Service Center. Every effort will be made to review and respond to your request as quickly as possible.

Responsibility for Member

You must provide primary care and referral services to the member until you receive a letter stating that the Division has transferred the member out of your PCC practice. If the Division denies your request to transfer a member, you must continue to provide primary care and referral services to that member, according to the terms of the PCC Provider Agreement.

Questions

Call the PCC Plan Hotline at 1-800-682-1061 if you have questions about member transfers.

Transportation

Authorization

MassHealth Standard and MassHealth CommonHealth members are eligible for taxi or chair-van transportation to and from providers of MassHealth services when personal transportation resources are unavailable and public transportation is either unavailable or not suitable to the member's medical condition.

To arrange for transportation, you must authorize transportation services in advance by submitting a completed PT-1 (Prescription for Transportation) form to the Division's Transportation Authorization Unit. If you would like a supply of PT-1 forms, please submit a request in writing to the following address or fax number.

Unisys
ATTN: Forms Distribution
P.O. Box 9101
Somerville, MA 02145
Fax: (617) 576-4087

Not all MassHealth members are eligible for taxi and chair-van transportation services. See 130 CMR 450.105 in Subchapter 1 of your provider manual for a list of covered services for each MassHealth coverage type.

Questions

You may call the Transportation Authorization Unit at the MassHealth Customer Service Center at 1-800-841-2900 for questions and information about transportation services.

Verifying Member Eligibility

Introduction

The Recipient Eligibility Verification System (REVS) contains information about a MassHealth member's eligibility, coverage type, PCC Plan or MCO enrollment status, and third-party coverage. You may access the system through the automated voice response system or a point-of-service (POS) device using the member's social security number or MassHealth card number. For PCC Plan members, the REVS message will give the name and telephone number of the member's PCC.

Checking REVS

Verify member information both when scheduling appointments and when the member arrives for services. Checking REVS before the date of service may help you determine potential issues with scheduling appointments, such as whether a member has another PCC or MCO, or is no longer eligible for MassHealth. Checking REVS on the date of service will significantly increase your chances of payment for the delivery of service. REVS contains eligibility information from the current day back through the previous six months. Encourage all members to carry their MassHealth cards with them whenever they seek medical care. You may also want to keep a photocopy of the member's MassHealth card on file.

REVS Telephone Numbers

The complete set of REVS telephone numbers is listed in Appendix B.

Automatic Reenrollment

When Reenrollment Occurs

To be eligible for the PCC Plan, a member must be eligible for MassHealth. Any PCC Plan member who loses and later regains MassHealth eligibility may be automatically reenrolled with his or her previous PCC, as long as the PCC continues to practice in the region where the member lives.

Notification of the PCC and the Member

Reenrolled members will appear as new enrollees on your PCC Panel Report. Both the reenrolled members and the PCC practice will receive written notice of the reenrollment.

PCC Concerns and Assistance

Resource Telephone Numbers

Resources are available for PCCs who have questions and concerns about the PCC Plan, claims, or member issues. The complete list of telephone numbers for these resources appears in Appendix B.

PCC Plan Hotline

Call the PCC Plan Hotline at 1-800-682-1061 for information about the PCC Plan or MassHealth services.

The PCC Plan
Part 3: Initiatives

Network Management Services

Introduction

The PCC Plan Network Management Services is a comprehensive, clinically focused management system that monitors, measures, and analyzes health care delivery by PCCs. The major goal of Network Management Services is to improve member health.

Assistance Provided to PCCs

Network Management Services helps PCCs by

- measuring, monitoring, and promoting improvements in health care delivery and their results;
- conducting visits to PCC practices;
- producing reports and assisting PCCs in understanding their utilization statistics;
- conducting periodic, regional informational meetings; and
- performing information and referral activities and provider relations through the PCC Plan Hotline.

Major Components

The major components of Network Management Services are the production, use, and maintenance of reports, and communications to improve provider performance. The reports include the PCC Profile Report and ad hoc reports. Network Management Services communications include site visits by Regional Network Managers (RNMs) and the PCC Plan Hotline.

Site Visits

Network Management Services focus primarily on PCCs with 200 or more members. RNMs perform site visits to these PCCs to review the PCC Profile Reports, discuss how the measures reflect on the PCC practice, and help formulate opportunities for improvement. RNMs are available as a resource to all PCCs to respond to PCC concerns, assist in resolving issues, and inform and educate both the clinicians and their staff on PCC Plan policies and procedures.

PCC Plan Hotline

The PCC Plan Hotline is toll free and operated by PCC Plan Hotline Provider Service Representatives. You may call the PCC Plan Hotline at 1-800-682-1061 for information about the PCC Plan or MassHealth.

Behavioral Health Services

Provision of Services

PCC Plan members receive inpatient, outpatient, and emergency behavioral health (mental health and substance abuse) services through a network of hospitals, acute residential programs, outpatient clinics, psychiatrists, psychologists, day-treatment programs, and detoxification facilities.

Your Role as the PCC

Members do **not** need PCC authorization to get behavioral health services. However, you may assist members by contacting the Division's behavioral health contractor for services. PCC Plan members may also arrange for services themselves by calling the contractor directly. Both the PCC and the member may call the contractor at 1-800-495-0086.

Although a PCC does not authorize behavioral health services, it is important that PCCs screen for behavioral health conditions, suggest treatment with their patients when appropriate, and ensure that all care is coordinated.

Communication with Behavioral Health Providers

Behavioral health providers are encouraged to initiate contact with a member's PCC, provided that consent is obtained from the member, as required by law. Such communication is particularly important when behavioral health treatment involves hospitalization or the prescription of psychotropic medication. The Division expects and encourages collaboration between behavioral health providers and PCCs.

Questions

For more information or questions about accessing behavioral health services for PCC Plan members, call 1-800-495-0086.

Well-Child Care

Introduction

The Division provides enhanced reimbursement (in addition to PCC enhancements) to PCCs when they deliver a comprehensive range of screening, diagnosis, and treatment services to certain children according to the requirements of the Early and Periodic Screening, Diagnosis, and Testing (EPSDT) Schedule. PCCs should deliver well-child care visits in accordance with the EPSDT Schedule to all children who are members of the PCC Plan. Refer to Subchapter 1 of your provider manual at 130 CMR 450.140 through 450.150 for more information about EPSDT services.

Visits and Health Screens

Well-child-care must be provided according to the EPSDT Schedule. The EPSDT Schedule appears in Subchapter 1 of your provider manual (at 130 CMR 450.142(C)) and describes the minimum number of visits and the services that must be provided at each visit. If you identify a medical problem with a member, you must provide the appropriate clinical follow-up or refer the member to another provider for follow-up. MassHealth pays for follow-up treatment as medically necessary and as allowed under the member's coverage type, including medically necessary over-the-counter drugs for MassHealth Standard members under age 21.

Note: Some over-the-counter drugs require prior authorization. For members in coverage types other than MassHealth Standard, a letter from the member's doctor certifying that the drug is necessary for the life and safety of the member may also be required. See 130 CMR 406.000 of the *Pharmacy Manual*.

Document in the member's medical record all well-child care services provided, including health education.

Referrals for Well-Child Care

As part of the PCC Provider Agreement, you must provide well-child care in accordance with the EPSDT Schedule. In rare instances, you may refer a member to another MassHealth provider who will provide these services. If you refer a child to another provider for well-child services in accordance with the EPSDT Schedule, you are responsible to make sure that all exams are performed and that all age-appropriate screenings are provided. Document in the member's medical record all referrals, and the result of the referral visit.

Enhanced Reimbursement

All physicians, group practices, independent nurse practitioners, and community health centers who follow the EPSDT Schedule may receive an enhanced reimbursement. PCCs who are physicians or nurse practitioners must use an EPSDT modifier when billing to receive the enhanced reimbursement. The EPSDT enhancement is paid in addition to the PCC enhancement.

Reminder Letters

To remind members of the importance of well-child care services, the Division sends well-child care reminder letters to all PCC Plan members.

Questions

For more information about well-child care services, call the PCC Plan Hotline at 1-800-682-1061.

Quality Improvement Projects

Quality Management Unit

The PCC Plan's Quality Management Unit undertakes quality improvement projects to assess and improve the quality of care provided through the PCC Plan. The PCC Plan works with clinical subcommittees, which include PCCs, to develop measurements for specific health indicators, develop interventions, and remeasure the indicators to determine if the interventions were successful. You are encouraged to become involved. If you would like more information or would like to participate on the clinical subcommittees, please call the PCC Plan Hotline at 1-800-682-1061.

HEDIS

The Health Plan Employer Data and Information Set (HEDIS) is a set of health plan performance measures. HEDIS is issued by the National Committee for Quality Assurance, and standardizes the way health plans collect and report information on health care quality and service utilization. Examples of measures contained in HEDIS include breast and cervical cancer screening, and childhood immunization and well care. This information is obtained from claims and medical records. The PCC Plan uses HEDIS measures on an annual basis to help plan quality improvement activities.

PCCs can help the PCC Plan by responding promptly to all requests from the Division for medical records.

Targets for Improvement

Four areas currently targeted by the PCC Plan for quality improvement projects are:

- breast and cervical cancer screening;
- asthma management;
- well-child health care services for children and adolescents; and
- emergency-department services.

Prospective Interim Payment (PIP)

Cash Advance

The Prospective Interim Payment (PIP) is an optional monthly cash advance for PCCs. The payment is made at the beginning of each month and is equal to 25% of the average monthly payment for PCC Plan members in the previous quarter. To reconcile these advance payments, the Division subtracts the PIP amount from payments for the current quarter.

Questions

To enroll in the PIP Program or for general questions about the PIP, call the PCC Plan Hotline at 1-800-682-1061. If you have questions about PIP reconciliation, you may call the Provider Services Department at (617) 628-4141 or 1-800-325-5231.

Appendices

Appendix A: Services Not Requiring Referrals

Appendix B: Resource Numbers for PCCs

Appendix C: MassHealth Referral Form

Appendix A
Services Not Requiring Referrals

The services listed below **do not** require PCC referrals (see Division regulations at 130 CMR 450.118(I) in Subchapter 1 of your provider manual). This list of excluded services is subject to change. Refer to the most recent provider bulletins and regulations for the most current list of excluded services.

Please Note: Not all services listed below are covered for all MassHealth members. See Subchapter 1 of your provider manual at 130 CMR 450.105 for a list of covered services for each MassHealth coverage type.

- Abortion services
- Anesthesia services
- Any services authorized and delivered under the Division's home- and community-based services waivers for the elderly and mentally retarded
- Behavioral health (mental health and substance abuse) services
- Dental care
- Drugs (legend and nonlegend) and diabetic supplies
- Emergency care (including emergency department screening services)
- Family planning services and supplies
- HIV pre- and post-test counseling services
- HIV testing
- Homeless member services, when delivered by providers designated by the Division
- Hospice services
- Nursing facilities
- Sexually transmitted disease diagnosis and treatment when provided by entities that have contracts with the Massachusetts Department of Public Health
- State school intermediate care facilities for the mentally retarded
- Surgical pathology services
- Transportation to reimbursable medical care (PT-1 form is required)
- Vision care services in the following categories: visual analysis, frames, single vision prescriptions, bifocal prescriptions, and repairs

Appendix B
Resource Numbers for PCCS

PCC Plan Hotline..... 1-800-682-1061
For PCCs with questions about the PCC Plan and PCC Plan Network Management Services

Provider Services Department ..... (617) 628-4141 or 1-800-325-5231
For MassHealth provider questions about billing and claims payment

MassHealth Provider Enrollment..... 1-800-322-2909
For questions about PCC applications. For other provider enrollment issues, call (617) 210-5500

Behavioral Health 1-800-495-0086
For questions about mental health and substance abuse services and for referrals for PCC Plan members

MassHealth Prior Authorization 1-800-862-8341
For services that require prior authorization from the Division

MassHealth REVS Automated Voice Response 1-800-554-0042
To verify a member's MassHealth and managed care enrollment status. For questions about REVS, call the Help Desk.

Use the following numbers only when you cannot obtain the information using the REVS automated voice response number:

Eligibility operator 1-800-833-7582
REVS Help Desk (questions about your point-of-service (POS) Device, PC software, or problems accessing REVS) 1-800-462-7738

MassHealth Customer Service Center..... 1-800-841-2900
For members with concerns and questions about benefit coverage, transportation authorization, special programs, general eligibility information, enrollment in a health plan, and complaints

Appendix C
MassHealth Referral Form

The MassHealth Referral Form that appears on the back of this page is an example of the kind of form you should use to record referral information for retention in the member's medical record. You can copy the form from the back of this page, or you may develop a referral form of your own. If you use your own form for referrals, make sure that you include all the information requested on the model MassHealth Referral Form.

MassHealth Referral Form

To be completed by the referring provider:

Member's Name: _____ Member's ID #: _____

Referring Provider: _____ Telephone: (____) _____

Is Referring Provider the Primary Care Clinician (PCC)? Yes ☐ No ☐

PCC's name (if other than referring provider): _____

PCC's MassHealth Provider Number: _____

PCC's Telephone Number: _____

Reason for Referral: _____

_____

_____

Services Requested: _____

Number of Visits or Services Authorized: _____ Duration of Referral: _____

To be completed by the provider of the referral services, and returned to the referring provider:

Findings: (physical exam, treatment, recommendation)

Date(s) of Service: _____

_____

Signature of the Provider of the Referral Services Date